



ANDOVER PEDIATRIC DENTISTRY

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FINANCIAL AGREEMENT

Thank you for choosing us to provide your child's dental care. We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our business office staff.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your child's coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.
- You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which vary from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for noncovered services, along with deductibles and copayments are due at the time of treatment.

PAYMENT POLICY

- We accept cash, personal checks, debit cards, Visa, MasterCard, American Express, Discover and CareCredit.
- After dental insurance has paid its portion, a statement is sent to the mailing address on record, for the remaining balance. Payment is expected within 30 days of the statement date, to avoid finance charges.
- If the insurance company does not pay in full within 45 days, it will be your responsibility to pay the balance due within 30 days.
- We do not file claims for medical insurance.

PATIENTS WITHOUT INSURANCE COVERAGE: We provide written estimate of fees, and payment is expected at each visit for services rendered.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at that visit.

RETURNED CHECKS: A \$25.00 charge applies when a check is returned by the bank.

FINANCE CHARGES AND COLLECTION FEES: Fees are assessed once an account has been turned over to our collection agency. A reasonable amount of time is allowed for cooperation between the office and the subscriber regarding other options; i.e... assignment of agreed payment plan options, etc... before this action is taken.

OVER DUE BALANCE: An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt: an interest rate of 30% on the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with the collection of your debt.

MISSED APPOINTMENT POLICY

BROKEN OR MISSED APPOINTMENTS: Appointments not kept or changed with less than 48 hours notice are considered broken. Broken appointments will be rescheduled during the morning hours and subject to additional fees. Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment.

FEE FOR MISSED APPOINTMENT IF 48-HOUR NOTICE NOT GIVEN. To reschedule or cancel an appointment, you must notify us at least forty-eight (48) hours in advance to avoid a missed appointment fee of up to \$50. This fee may need to be paid before any future appointments are scheduled. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

RECORDS AND REIMBURSEMENTS: Original records including radiographs are the property of this office. If you desire we will provide you with a copy of your child's record or radiographs for a nominal duplication fee.

CONSENT & AUTHORIZATION: I authorize dental treatment on my child and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of Andover Pediatric Dentistry, Maritza Morell, DMD PC. Without any reservations, I agree to abide by the policies outlined herein.

Form completed by:

Name _____ Signature _____

Relationship to child _____ Date _____

Are you the person legally responsible for this child? Yes _____ No _____

Reviewed by staff member _____ Date _____